Comprehensive, Supports and ABI Waiver Services

Service index as of 7-27-2015

Self-directed services available!

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- Homemaker *New!*
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***Rates with modifiers may vary when paid from the posted rate.** Codes with modifiers, such as UA, pay the rate with a multiplier that corresponds to the modifier, i.e. UA=0.67597016. When paid, rates for codes with modifiers may vary by a few cents depending on the number of units billed X the code with the modifier. The rate listed is for one unit X the code and modifier. Please see the posted rate table for the actual value of the multiplier for each modifier used in the waivers.

****One-Year Rate Increase for Levels 4, 5, & 6.** The 2015 legislature approved a $3 million dollar increase to the service rates for levels 4, 5 and 6 for the next fiscal year from July 1, 2015 to June 30, 2016. Providers should reference the new fee schedules posted to our website to bill. *The increase will occur by adding the U8 modifier to services, which gives a 4.6% increase to a rate.*

Service	Programs	Code(s)		Rate(s)	Unit
Adult Day Services	Comprehensive Waiver	S5100	Basic Care	$2.70	15
	Supports Waiver	S5100 TF	Intermediate Care	$3.51	minute
	ABI Waiver	S5100 TG	High level of care	$5.40	unit

Adult Day Services are structured services consisting of meaningful day activities that maximize or maintain skills and abilities, keep participants engaged in their environment and community through optimal care and support; actively stimulate, encourage, develop, maintain, personal skills; introduce new leisure pursuits, establish new relationships, improve or maintain flexibility, mobility, and strength; or build on previously learned skills.

Adult Day Services provide active supports which foster independence, are person-centered to the maximum extent possible, as identified in the participant's plan of care. Adult Day Services also include personal care, protective oversight, and health maintenance activities such as medication assistance and routine activities that may be provided by unlicensed direct support professionals identified in the plan of care.

Adult Day Services are usually provided in a congregate setting. When provided in congregate community setting, there must be staff on-site within immediate proximity to allow staff to provide support and supervision, safety and security, and provide activities to keep the person engaged in their environment.

Transportation into the community to shop, attend recreational and civic events, or other community activities and resources, is a component of Adult Day Services and is included in the rate to providers.

A Participant receives a tiered service approved in the plan of care based upon need, according to the following tiers descriptions:

Basic Level of Care
Levels 1 and 2 on the Level of Service Need grid will generally be in this tier. Service tier requires limited staff supports and personal attention to a participant daily due to a moderately high level of independence and functioning. Behavioral needs, if any, can be met with medication or informal direction by staff. The person may have periods of time with indirect staff supervision where staff are onsite and available through hearing distance of a request.

Intermediate Level of Care
Levels 3 and 4 on the Level of Service Need grid will generally be in this tier. Service tier requires full-time supervision with staff available on-site within line of sight due to significant functional limitations, medical and/or behavioral needs. Behavioral and medical supports are not generally intense and can be provided in a shared staffing setting. Regular personal attention is given throughout the day for personal care, reinforcement, community or social activities.

High Level of Care
Levels 5 and 6 on the Level of Service Need grid will generally be in this tier. Service tier requires full-time supervision with staff available on-site within absolute line of sight and frequent staff interaction and personal attention for significant functional limitations, medical and/or behavioral needs. Support and supervision needs are moderately intense, but can still generally be provided in a shared setting unless otherwise specified in the plan of care. Frequent personal attention given throughout the day for reinforcement, positive behavior support, personal care, community or social activities.

Transportation services in the waiver are not intended to cover activities on a person's Adult day service

schedule where the provider is part of the activity. Transportation services on the waiver can be used if a person in Adult Day services wants to go to an activity outside of their normal schedule and if the provider is not a part of the activity. It is a stop gap service, so the person can get a ride, but does not have to pay for the provider to be with them for a "service" other than the ride. The rate for Adult Day services includes the cost of routine transportation.

Adult Day Services may be provided in the participant's home if the team decides the home is a more appropriate place to receive the service and the approved plan of care supports the medical, behavioral, or other reason for the service to be provided in the person's home. If this option will be utilized during the provision of this service, the case manager must document it in the "objective" portion in the IPC for this service.

Scope and Limitations

No unit cap on Supports Waiver. On Comprehensive & ABI Waivers, approved units will be based on individual level of service need and must fit within the assigned budget. Adult Day Services are available to individuals who are 21 years of age or older. This is not a habilitation service.

- Approved units will be based on individual level of support need and must fit within the assigned budget.
- Adult Day Services focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the service plan. Services may serve to reinforce skills or lessons taught in other settings.
- Individuals in Adult Day Services may not be paid for work activities performed during this service.
- Personal care is included in this service and therefore stand-alone personal care is not permitted during the delivery of this service.
- Participants who receive this service may also receive Community Integration services, Supported Employment and Prevocational services. A participant's service plan may include two or more types of non-residential habilitation services as long as service times do not overlap.

Behavioral Support Services	Comprehensive Waiver Supports Waiver ABI Waiver	T2025	Prior Authorization number (PA#)	Per event

Behavioral Support Service includes training, supervision, or assistance in appropriate expression of emotions and desires, compliance, assertiveness, acquisition of socially appropriate behaviors, and the reduction of inappropriate behaviors through the implementation of positive behavior support and interventions. Behavioral Support Services can also be accessed for the intent purpose of reducing the use of restrictions and restraints within a participant's current plan of care or service environment.

Reimbursable activities:

- Observation of the person and environment for purposes of development of a plan and to determine baseline
- Development of a behavioral support plan and subsequent revisions utilizing positive behavior supports and interventions.
- Obtain consensus of the Individualized Support Team that the behavioral support plan is feasible for implementation.
- Training in assertiveness
- Training in stress reduction techniques
- Training in the acquisition of socially accepted behaviors
- Training staff, family members, roommates, and other appropriate individuals on the implementation of the behavioral support plan
- Consultation with team members

Scope and Limitations

Behavioral Support services provided must not be covered under any billable service through the Medicaid State Plan. All billable activities will follow the Division policy for cost and must be prior authorized.

Other Activities that are not allowed under this service:

- Aversive techniques – Any techniques not approved by the person centered planning team and the

provider's human rights committee.

- Therapy services furnished to the participant within the educational/school setting or as a component of the participant's school day.
- Services furnished to a minor by a parent(s), step-parent(s), or legal guardian.
- Services furnished to a participant by the participant's spouse.

Provider Qualification Note

A provider of Behavioral Support Services shall have either:

- A Master's Degree and be a Board Certified Behavior Analyst or have a similar nationally recognized certification in positive behavior supports with approval from the Division, or
- A current license to practice Psychology from the Wyoming Board of Psychology and have specific training on positive behavior supports from a nationally recognized organization.

Case Management	Comprehensive Waiver Supports Waiver ABI Waiver	T2022 or T1016	$268.86 $10.90	Month 15 min unit

Case management is a service to assist participants in gaining access to needed waiver and other Medicaid State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case management is now available as either a 15 minute unit or a monthly unit.

Traditional case management

Case managers are responsible for the following functions for participants choosing NOT to self-direct services:

- Assessment and/or reassessment of the need for waiver services;
- Initiating the process to evaluate and/or re-evaluate the Participant's level of care
- Linking waiver participants to other Federal, state and local programs;
- Development of the plan of care adhering to the Division's policies and procedures;
- Coordination of multiple services and/or among multiple providers;
- Ongoing monitoring of the implementation of the plans of care;
- Ongoing monitoring of participants' health and welfare;
- Addressing problems in service provision, including problems found during the ongoing monitoring of the implementation of the plan of care or concerns with a participant's health and welfare;
- Responding to participant crises;
- Reviewing service utilization and documentation of all services provided on a monthly basis to assure the amount, frequency, and duration of services are appropriate.
- Using the CRT and ECC processes as needed to help meet the participant's unmet needs

The case manager is required to complete the following responsibilities monthly in these cases:

- A home visit with the participant present to monitor the participant's health and welfare, as well as to discuss satisfaction with services and needed changes to the plan of care with the participant.
- Direct contact each month with participant and/or guardian, which must include the home visit but may also include observation of services to assess implementation of the plan of care, telephone contact with participant or guardian and/or meeting with the participant and/or guardian to complete follow up on concerns identified through incident reports, complaints or identified through other means.
- Follow-up on all concerns or questions raised by the participant, guardian or plan of care team or identified through incident reports, complaints or through observation of services.
- Reviewing service utilization and provider documentation of service, identify significant health changes, trends through incident reports, evaluate the use of restraints and restrictive interventions, interview participant and/or guardian on satisfaction with services, and complete follow-up on concerns identified in any of these processes.

Case Management when waiver services are self-directed

Case Managers are responsible for the following functions for participants who self-direct services:

- Assessment and/or reassessment of the need for waiver services;
- Initiating the process to evaluate and/or re-evaluate the Participant's level of care
- Working with the participant, Support Broker and other team members on development of the plan of care that addresses the participant's needs, and submission of the plan of care to the Division adhering to the Division's policies and procedures;
- Ongoing monitoring of the implementation of the plan of care, including monitoring self-directed services and traditional services;
- Ongoing monitoring of participants' health and welfare;
- Addressing problems in service provision, including problems found during the ongoing monitoring of the implementation of the plan of care or concerns with a participant's health and welfare, working with the participant, Support Broker and plan of care team members as appropriate;
- Responding to participant crises;
- Reviewing service utilization, the self-directed budget, and documentation of all services provided on a monthly basis, including all self-directed services, to assure the amount, frequency, and duration of services are appropriate.

The role of the Case Manager is to monitor the implementation of the Participant's plan of care and provide coordination and oversight of supports but not "hands on" involvement in identifying and securing supports. Those are duties of the Support Broker.

The case manager is required to complete the following monthly on these cases:

- A home visit with the participant present to monitor the participant's health and welfare, as well as to discuss satisfaction with services and needed changes to the plan of care with the participant.
- Direct contact each month with participant and/or guardian, which must include the home visit but may also include observation of services to assess implementation of the plan of care, telephone contact with participant or guardian and/or meeting with the participant and/or guardian to complete follow up on concerns identified through incident reports, complaints or identified through other means.
- Follow-up on all concerns or questions raised by the participant, guardian or plan of care team or identified through incident reports, complaints or through observation of services.
- Reviewing service utilization and provider documentation of service, identify significant health changes, trends through incident reports, evaluate the use of restraints and restrictive interventions, interview participant and/or guardian on satisfaction with services, and complete follow-up on concerns identified in any of these processes.

Some participants self-directing services may choose not to have a Support Broker. This may be because they are skilled enough to complete those tasks themselves (as determined through assessment) or they have natural supports that can assist them. In these cases, the general oversight responsibilities of the case manager are sufficient to monitor the participant's self-direction efforts.

Subsequent assessments

These assessments are provided as part of ongoing case management and will include the necessary collaboration of professionals to assess the needs, characteristics, preferences and desires of the waiver participant. Case managers shall initiate and oversee subsequent assessments, regardless of payment source. These include the psychological assessment, if needed for continued eligibility and any other assessments that are necessary to determine the participant's needs and are not available through the Medicaid State plan. All assessments shall be prior authorized by the Division.

Scope and Limitations

Case management is available as either a 15 minute unit or a monthly unit. Each unit has minimum requirements in order to bill:

Monthly unit

* The monthly unit may be billed on or after the last day of the month and requires a minimum of two hours of billable services to be documented in order to bill, but all billable services must be documented for the entire month. A home visit is required each month with the participant present.

Case Managers shall be reimbursed up to 1 unit per month and shall provide a minimum of 2 hours of documented case management service and have completed a home visit each month in order to bill. Service time may consist of direct participant contact, guardian contact, phone calls to the participant or guardian, monitoring the participant in services, following up on concerns or questions regarding the participant, team meetings, plan of care development or updating, the monthly home visit, and service documentation review.

15 minute unit

* The rate for the 15 minute unit is based on the same methodology that the monthly unit was based on and allows an average of 6 hours of case management to be provided a month. One unit a month of case management is required each month. The number of units on a plan may not exceed 296 units annually. In cases of extraordinary need for case management, the ECC may authorize a temporary increase above 296 units. Case managers may use units based on the need of the participant or guardian up to the approved amount. At least one (1) 15-minute unit per month will be required for all participants, so the case manager can keep in contact with the participant through a call or a personal visit to ensure the participant is satisfied with services and has no unmet needs or concerns.

Home Visit Requirements for 15 minute unit

* Monthly home visits are only required for a participant who receives any type of residential services, including residential habilitation, special family habilitation home, and supported living. The visit must be done in the home with the participant present.
* Quarterly home visits are required to non-residential participants and must be done in the home with the participant present. (Monthly home visits may still be completed).
* The case manager may complete additional home visits for times of crisis or other times when a participant might request or need more frequent home visits.

Billable Time

A billable unit of case management is any task or function defined by the Behavioral Health Division as a case management activity that only the case manager or case management agency can provide to or on behalf of the participant and guardian.

Billable time may be cumulative during the span in which a provider bills. Billable case management services include:

- Plan Development
- Plan Monitoring/Follow-up (Includes documentation review)
- Service Observation
- Home Visit
- Team Meetings
- Participant Specific Training
- Face to Face Meeting with Participants, Guardian, Family
- Advocacy and Referral
- Crisis Intervention
- Coordination of Natural Supports
- Providing and Discussing Choice
- Completing Monthly responsibilities,
- Quarterly service observations and interviews,
- Division quarterly reports and other reports as required by BHD within the specified timeframe
- Quarterly meetings with the backup case manager assigned.

Non-billable Time

- Ancillary activities, such as clerical tasks like mailing, copying, filing, faxing, drive time, transportation costs/mileage, or supervisory/administrative activities are not billable case management activities, although the administrative cost of these activities and other normal and customary business overhead costs have been included in the reimbursement rate for billable activities
- Time spent with the Participant or guardian for social reasons are not considered billable time unless billable case management time is also occurring. Incidental contact and social exchanges

are part of conducting and building a business and offering customer service, and are not considered a case management service by the Centers for Medicaid and Medicare Services (CMS).
- Travel time is a part of the rate for the service and is not a billable service.

Relatives
A relative, parent, legally responsible person, or guardian may no longer provide case management services to their ward/related participant under conflict free case management.

If a participant is hiring a relative through self-direction, the participant's case manager shall not have a conflict of interest with the relative or participant, which means the case manager shall not be a relative of the employee, participant, or the participant's legal representative. If a relative provides services to a related waiver participant as a service provider, an employee of a service provider, or a self-directed employee, then the case manager on the participant's plan of care shall not have a conflict of interest to the relative provider or the participant, which means the case manager shall not be employed by or related to the relative provider or the participant (i.e. Sibling, child, grandparent, aunt, uncle, or other parent/step-parent, cousin, step family, or the participant's guardian).

If a participant is hiring a relative (non-parent or guardian) through self-direction, the participant's case manager shall not have a conflict of interest with the relative or participant, which means the case manager shall not be a relative of the employee, participant, or the participant's legal representative.

Case management services on the waiver can only be billed and reimbursed after the plan of care is approved by the Division. Prior to entrance to the waiver, targeted case management services are reimbursed through the Medicaid State Plan.

Provider Qualifications note:

Annual Training
A case manager must complete (8) eight hours of annual training in areas specified by the Division each year to recertify. Individuals must keep certificates or confirmation of attendance and provide a copy for agency personnel files if working for an agency.

The proposed revised rules for the Conflict Free Case Management includes the following requirements.

Case managers must have one (1) of the following:

(I) A Master's degree from an accredited college or university in one (1) of the following related human service fields:
- (1.) Counseling,
- (2.) Education,
- (3.) Gerontology,
- (4.) Human Services,
- (5.) Nursing,
- (6.) Psychology,
- (7.) Rehabilitation,
- (8.) Social Work,
- (9.) Sociology, or
- (10.) A related degree, as approved by the Division.

(II) A Bachelor's degree in one (1) of the related fields from an accredited college or university, and one (1) year work experience as a case manager or in a related human services field.

(III) An Associate's degree in a related field from an accredited college, and four (4) years of work experience as a case manager or in a related human services field;

A case manager employed by an agency or certified prior to the effective date of the newly revised rules may continue to provide case management services without meeting the criteria as long as the case manager demonstrates reasonable and ongoing efforts to obtain the required qualifications during a three-year transition period from that date. The Division shall accept 60 credit hours with at least 24 credit hours in a related field and five (5) years of work experience as a case manager on any of the

Wyoming waivers as an exception for not meeting the required education requirements. Persons seeking to qualify as a case manager shall obtain the additional education requirements prior to January 1, 2018. The Division shall terminate the certification of a case manager who fails to obtain the required education.
A case manager shall obtain and maintain his or her own National Provider Identifier (NPI) number for case management services through the Medicaid enrollment process.

A provider agency certified to provide case management services shall:

(I) Have policies and procedures for backup case management for each person's caseload and meet with their designated backup to review all participant cases on a quarterly basis, with the review documented in case notes.

(II) Have each case manager obtain proof of competency demonstrated through successful completion of the Division-approved case management training curriculum initially and annually.

(III) Document on the plan of care that they have no conflict of interest with the participant or family.

(IV) Meet the following conflict free requirements:

(1.) The case management agency and any managing employee may not own, operate, be employed by, or have a financial interest in or financial relationship with any other person or entity providing waiver services on the participant's individual plan of care.

(2.) The case management agency may be certified in other waiver services, but shall not provide case management services to any participant that they are providing any other waiver services to, including self-directed services.

(3.) The owner, operator, or employee of a case management agency may not be related by blood or marriage to the owner, operator, or managing employee of any other waiver service provider on the participant's plan of care.

(4.) Any employee of a guardianship agency may not provide case management to any participant who is receiving any services from the guardianship agency.

(5.) Also, a case management agency may not:

a. Employ case managers that are related to the participant, the participant's guardian, and/or a legal representative served by the agency. If the case management agency is a sole proprietor, the case manager may not be related to the participant, the participant's guardian, or a legal representative served by the agency;

b. Make financial or health-related decisions on behalf of the participant receiving services from that agency, including but not limited to a guardian, representative payee, power of attorney, conservator or other position as defined by the Division; or

c. Provide case management services to, or live in the same residence of, any provider on a participant's plan in which they provide case management service.

(V) If a rural area of the State does not have a case manager without a conflict of interest for a participant, the participant or legally authorized representative may request to have a case manager with a conflict. If:

(1.) The Division confirms that there are no other case managers available in the region or a nearby region to provide case management, then the conflicted case manager may be approved on an annual basis.

(2.) A third party entity without a conflict shall be involved in the participant's team to mediate, advocate for the participant as needed, and address unresolved grievances for any conflicts that are approved.

(3.) This approval shall be subject to notice to and approval by the Centers for Medicaid and Medicare Services.

Child Habilitation Services	Comprehensive Waiver	T2027	*(ages 13 to 17)*	$3.49	15 minute
	Supports Waiver	T2027 HA	*(ages 0-12)*	$2.72	unit

Child Habilitation Services provide children with regularly scheduled activities (and/or supervision) for part of the day. Services include training, coordination and intervention directed at skill development and

maintenance, physical health promotion and maintenance, language development, cognitive development, socialization, social and community integration and domestic and economic management. This includes services not otherwise available through public education programs in the participant's local school district, including after school supervision, daytime services when school is not in session, and services to preschool age children.

Services may be provided at various times of the day in multiple settings, when other waiver services would not be more appropriate, such as Respite or Personal Care. Service may occur in a single physical environment or in multiple environments, including natural settings in the community. Training activities may involve children and their families.

Child Habilitation Services also includes the provision of supplementary staffing necessary to meet the child's exceptional care needs in a daycare setting. Coordination activities may involve the implementation of components of the child's family-centered and individualized service plans and may involve family, professionals, and others involved with the child as directed by the child's plan.

Transportation is included in the reimbursement rate.

Providers are responsible for both formal and informal training opportunities. The schedule must be individualized and the training objective must be meaningful. Progress on objectives shall be reported to the case manager monthly.

Scope and Limitations

This service is limited to children under age 18. There is no cap on the Supports Waiver. On the Comprehensive waiver, there is annual cap of 9400 units per year. Services approved must be based on assessed need and fit within the person's assigned budget.

This service is a 15-minute unit. A provider can receive reimbursement for up to two (2) participants at one time, with a limit of three (3) persons being supervised by a provider or provider staff at one time. The rate for this service, for children through age 12, does not include the basic cost of childcare unrelated to a child's disability that may be needed by parents or regular caregivers to allow them to work or participate in educational or vocational training programs. The "basic cost of child care" means the rate charged by and paid to a childcare center or worker for children who do not have special needs. The basic cost of childcare does not include the provision of supplementary staffing and environmental modifications necessary to provide accessibility at regular child care settings; these costs can be covered by this service. For children ages 13 through 17, the rate for the service has a modifier "add in" component to cover the amount of the child care cost, which is no longer required after age 12.

This service shall exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA). Child Habilitation Services include personal care services, so providers cannot be reimbursed for providing both services at the same time.

Child Habilitation Services cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency. Units shall be limited based upon the participant's need during non-school times and during summer & breaks.

Relative providers (excluding parents/stepparents) may provide this service.

Cognitive Retraining	Supports Waiver ABI Waiver	H2014		$8.02	15 minute unit

Training provided to the person served or family members that will assist the compensation or restoring cognitive function (e.g. ability/skills for learning, analysis, memory, attention, concentration, orientation, and information processing) in accordance with the Plan of Care.

Community Integration Services	Comprehensive Waiver Supports Waiver ABI Waiver	T2021 T2021 TF T2021 TG	Basic care Intermediate Care High Level of Care	$2.97 $3.86 $5.94	15 minute unit

Community Integration Services services offer assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the

participant's private residence or other residential living arrangement.

Services should be furnished in any of a variety of settings in the community and are not limited to fixed-site facilities. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, community networking, and personal choice. Making connections with community members is a strong component of this service provision.

Community Integration services focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the service plan. Services may serve to reinforce skills or lessons taught in other settings.

Services must be furnished consistent with the participant's person-centered plan and include options and opportunities for community integration, relationship-building, and an increased presence in one's community. Adult educational supports are an approved activity of this service.

This service must be delivered differently from Adult Day Services. This service requires a mixture of staff time helping a participant plan, access, participate, and interact with community members, businesses, volunteer activities, libraries, cultural, religious, or art centers, and build and maintain social connections at least half of the time each week during the provision of services.

Community Integration Services are habilitative services that provide assistance and training with the acquisition and retention of skills. 50% of services must address planning and participating in community integrated activities. Conversely, Adult Day Services is not habilitative and does not require community integrated activities. Adult Day Services are supervision and support services to keep people who need the service in a safe, supervised setting that does not require the activity and objectives as habilitation services. Adult Day Services do not implement as many opportunities for getting participants out into the community or participating in community events mainly due to comprised health issues and significant limitations of participants.

This service may not be used if participants are paid for work activities at the facility or other location.

Personal care needed is a component part of the service as necessary to meet the needs of a participant, but may not comprise the entirety of the service nor can personal care services be billed in conjunction with this service during the same time.

Participants, who receive this service, may also receive Adult Day Services, Supported Employment and Prevocational services on the same plan (but not at the same time). A participant's service plan may include two or more types of non-residential habilitation services as long as service times do not overlap.

A Participant receives a tiered service approved in the plan of care based upon need, according to the following tiers descriptions:

Basic Level of Care
Levels 1 and 2 on the Level of Service Need grid will generally be in this tier. Service tier requires limited staff supports and personal attention to a participant daily due to a moderately high level of independence and functioning. Behavioral needs, if any, can be met with medication or informal direction by staff. The person may have periods of time with indirect staff supervision where staff are onsite and available through hearing distance of a request.

Intermediate Level of Care
Levels 3 and 4 on the Level of Service Need grid will generally be in this tier. Service tier requires full-time supervision with staff available on-site within line of sight due to significant functional limitations, medical and/or behavioral needs. Behavioral and medical supports are not generally intense and can be provided in a shared staffing setting. Regular personal attention is given throughout the day for personal care, reinforcement, community or social activities.

High Level of Care
Levels 5 and 6 on the Level of Service Need grid will generally be in this tier. Service tier requires full-time supervision with staff available on-site within absolute line of sight and frequent staff interaction and personal attention for significant functional limitations, medical and/or behavioral needs. Support and supervision needs are moderately intense, but can still generally be provided in a shared setting

unless otherwise specified in the plan of care. Frequent personal attention given throughout the day for reinforcement, positive behavior support, personal care, community or social activities.

Scope and Limitations

Service is available for participants ages 21 and older who are no longer receiving school services.

There is no cap on the Supports Waiver. On the Comprehensive waiver & ABI Waiver, approved units will be based on individual level of service need and must fit within the participant's assigned budget, unless the highest tier is used as follows:

- The highest tiered rate for Community Integration service called "high level of care" will be available to participants, who want help building meaningful relationships and social connections in the community with a more individualized approach from the provider. A participant with any level of service need score may add the high level of care rate for this service to the plan of care for individual services or services with up to one other waiver participant where the entire time is spent solely in the community and not in a facility.

Any relative providers may provide this service. Community Integration services cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency.

Transportation into the community to shop, attend recreational and civic events, or other community activities and resources, is a component of Community Integration Habilitation services and is included in the rate to providers.

Services cannot exceed an average weekly amount of 35 hours for those in residential habilitation services, who do not want to attend a day service program but still require supervision in the home. The 35 hour cap can be a combination of day services in a week, including Adult Day Services, Companion, or Prevocational services.

Provider Qualifications Note

Within one year of being certified in this service, one (1) staff person working in this service must be certified in a nationally recognized supported employment curriculum and demonstrate that a portion of their time each month is spent training direct care staff on exploring employment interests, working on job readiness skills, or other employment related activities with participants.

Companion Services	Comprehensive Waiver Supports Waiver ABI Waiver • May be self-directed	S5135 S5135 HQ	Individual Group up to 3	$3.85 $1.93	15 minute unit

Companion services include non-medical care, supervision, socialization and assisting a waiver participant in maintaining safety in the home and community and enhancing independence. Companions may assist or supervise the individual with such tasks as meal preparation, laundry, and shopping, but do not perform these activities as discrete services. Companions may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. Companion services include informal training goals in areas specified in the individual plan of care. The provision of companion services does not entail hands-on nursing care, but does include personal care assistance with activities of daily living as needed during the provision of services. Routine transportation is included in the reimbursement rate.

Scope and Limitations

This service is available to participants ages 18 and up. It is a 15-minute unit and is available as a 1:1 service or as a group rate serving 2 people or 3 people. Service may be provided up to nine (9) hours a day except for special events or out of town trips. There is no cap on the Supports Waiver. On the Comprehensive Waiver, the Companion service unit cap cannot exceed an average weekly amount of 35 hours for those in residential habilitation services, who do not want to attend a day service program but still require supervision in the home. The 35 hour cap can be a combination of day services in a week, including Adult Day Services, Community Integration, or Prevocational services. This service may not be used in conjunction with residential habilitation, so service times may not overlap.

Companion Services provided to participants ages 18 through 21 may not duplicate or replace services that are covered under IDEA and cannot be provided during school hours.

With the group rate, providers can provide companion services for two participants or three participants at the same time but must document at the rate for the specific group. Providers cannot serve children and adults at the same time unless authorized in advance by the Division.

Relative providers (excluding parents/stepparents) may provide this service.

Companion services cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency.

Crisis Intervention Support	Comprehensive Waiver Supports Waiver ABI Waiver	H2011	$6.18	15 minute unit

Crisis Intervention services may be added to a plan for situations where a participant's tier level may not provide sufficient supervision for specific activities, medical conditions or occurrences of behaviors or crisis, but the extensive support is not needed at all times. The service may only be provided to a participant age 18 years or older in habilitative residential or day services.

Crisis Intervention provides funding for extra support from another staff to supervise a participant in the habilitation service during times of periodic behavioral episodes where the person is a danger to oneself or others, or if the participant has an occasional or temporary medically fragile situation and is at risk of imminent harm without the extra staff support.

Intervention for behavioral purposes is not intended for watching the person should the behavior occur, but for the purpose of supporting the participant when the need arises, using positive behavior supports and non-violent, non-physical crisis intervention services to de-escalate a situation, teach appropriate behaviors and keep the participant safe until the participant is stable.

Quantity of service may be approved by the Division's Clinical Review Team(CRT) and shall be based on verified need, evidence of the diagnosis or condition requiring this service. Documentation of progress and data on behaviors and the outcome of the intervention services must be submitted to the case manager and Division at the frequency specified in the approved plan of care. Service must be used in conjunction with another habilitation service for those over 18.

Provider Qualification note

Within one year of certification in this service, an accredited provider serving more than five (5) participants with restrictive interventions in their plans are required to have a supervisor or trainer successfully complete positive behavior support curriculum through a nationally recognized positive behavior support curriculum approved by the Division. An additional supervisor shall be certified for every ten (10) additional participants with restrictive interventions in their plan. If the service is used for participants with critical medical support needs, then the training is not necessary.

Dietician	Comprehensive Waiver Supports Waiver ABI Waiver	S9470	$28.66	Session

Dietician Services provided by a registered dietician include menu planning, consultation with and training for caregivers, and education for the participant served. The service does not include the cost of meals. Dietician services are available on the Medicaid State plan so the waiver service is an extension of the Medicaid State plan. Dietician services may be used when the Medicaid state plan services have been exhausted. Without this service, certain participants would receive inadequate nourishment and would require institutionalization. The dietician services are those services designated in the participant's Individual Plan of Care and ordered by a physician. The clientele served by this service show a pattern of chronic and unusual need requiring dietician services. Chronic needs encompass conditions such as severe obesity, poor food choices that compromise health, special diets approved by a physician for specific diagnoses or severe allergies. Service is limited to services not provided under the Medicaid State Plan. Relative providers shall not provide this service. At least 30 minutes of service must be provided per session in order to bill.

Environmental Modification	Comprehensive Waiver Supports Waiver ABI Waiver	S5165 NU S5165	New Repair	PA#	Per event

Environmental modifications include those functionally necessary physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant.

Scope and Limitations

Lifetime cap of $20,000 per family, regardless of waiver. Cap begins for purchases made after July 1, 2013 on previous Wyoming Waivers. A critical health or safety service requests that exceeds the lifetime cap is subject to available funding and approval by ECC.

As stated in Wyoming Medicaid Rules, Chapter 44, Section 6: Environmental Modifications shall meet at least two of the following criteria for approval by the Division:

1. Be functionally necessary,
2. Contribute to a person's ability to remain in or return to his or her home and out of an ICF/ID setting,
3. Be necessary to ensure the person's health, welfare, and safety.

Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

- Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Scope and Limitations of this service are found in Medicaid Rule Chapter 44. Participants cannot have both Individual Goods and Services and Environmental Modifications on the plan.
- Any adaptations that are covered by Medicaid, a state independent living center, or vocational rehabilitation are excluded.
- Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

All services shall be provided in accordance with applicable State or local building codes.

The case manager will follow the process identified in Chapter 44, Section 7. The case manager should not obtain quotes until the overall scope of the project is approved by the Division.

The Division may schedule an on-site assessment of the environmental concern including an evaluation of functional necessity with appropriate professionals under contract with the Division. The Division may use a third party to assess the proposed modification and need for the modification to ensure cost effectiveness.

Sale of environmental modifications must not profit the participant or family.

Case Manager shall not give copies of the individual plan of care to the environmental modification provider. The environmental modification provider shall receive a copy of the approved service authorization printout.

Relative providers (including parents/stepparents) may provide this service in accordance with Chapter 45, adhering to the following requirements:

- They are a certified Medicaid Waiver Environmental Modification Provider; and
- The Division receives at least one other bid from another provider to ensure cost effectiveness.

Employment Discovery and Customization	Comprehensive Waiver Supports Waiver ABI Waiver	H2025	$6.50	15 minute unit

Employment Discovery and Customization is the individualized determination of the strengths, needs, and interests of the participant and is designed to meet the specific needs of the employee and employer relationship. Employment discovery and customization includes employment developed through job carving, self-employment or entrepreneurial initiative, or other job development or restructuring strategies that result in job responsibilities being customized and individually negotiated to fit the needs of participants. Employment discovery and customization presumes the provision of reasonable accommodations and supports necessary to perform functions of a job that is individually negotiated and developed.

Scope and Limitations

Employment discovery and customization is a 1:1 support service and has a limited time frame of 12 months. This service is reimbursed at a 15 minute unit rate. An additional 12 months may be approved by the Division upon review of the progress made the prior year. There is annual cap of 400 units, where 100 units will be authorized initially in order to develop a strengths, needs, and interest assessment and an employment plan. After submitting the employment plan, an additional 300 units may be approved to explore various types of job customization, self-employment, or entrepreneurial opportunities. Service is available for any participant ages 18 and older. Documentation for any supported employment service must be maintained in the provider and case manager's file for each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation or Workforce Services) or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq./school district). Services cannot be provided during the school hours set by the local school district.

Provider Qualifications Note

Within one year of being certified in these services, 1 staff person working at least 50% of their time as a job coach/developer must be certified in a nationally recognized supported employment curriculum if serving up to 10 participants in these services, and for every 10 participants after-one additional staff working at least 50% of their time as a job coach/developer must be certified. If a provider does not hire staff then the provider must meet these requirements.

Homemaker	Comprehensive Waiver Supports Waiver ABI Waiver • May be self-directed	S5130	$3.85	15 minute unit

Services consisting of general household activities such as meal preparation and routine household care, which are provided by a trained homemaker when the individual regularly responsible for these activities is unable to manage the home and care for himself/herself or others in the home or when the person who usually does these things is temporarily unavailable or unable to perform the tasks. This service does not include direct care/supervision of the waiver participant.

There is no cap on the Supports Waiver. Comprehensive Waiver cap per year is a maximum of 3 hours per week per household or 624 units. Service is not available to participants who receive residential habilitation or special family habilitation home services on the waiver. Relative providers (excluding parents/stepparents) may provide this service.

Independent Support Broker	Comprehensive Waiver Supports Waiver ABI Waiver • May be self-directed	T2041	$9.44	15 minute unit

Independent Support Brokerage assists the participant (or the participant's legal representative, as appropriate) in arranging for, directing and managing services. Serving as the agent of the participant or legal representative, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. The Support Broker offers practical skills training to participants and their legal representatives to enable them to independently direct and manage waiver services. Support Brokers serve at the discretion of the participant and/or their legal representative. Examples of skills training include providing information on

recruiting and hiring direct care workers, managing workers and providing information on effective communication and problem-solving. The service includes providing information to ensure that participants understand the responsibilities involved with directing their services. The extent of the assistance furnished to the participant or family is specified in the individual plan of care. This service does not duplicate other waiver services, including case management. Other functions include assisting the participant in:

1. Identifying immediate and long-term needs, preferences, goals and objectives of the participant for developing the individual plan of care.
2. Making decisions about the individual budget.
3. Developing options to meet the identified needs and access community services and supports specified in the individual plan of care.
4. Negotiating rates of payments and written agreements with service providers.
5. Selecting, hiring and training service providers, as applicable.
6. Developing and implementing risk management agreements and emergency back-up plans.
7. Conducting self-advocacy and assisting with employee grievances and complaints.
8. Assisting with filing grievances and complaints to outside entities, including the appropriate Financial Management Service provider and/or Division.
9. Providing information and practical skills training to the participant in the following areas:
    a. Person-centered planning and its application.
    b. The range and scope of individual choices and options.
    c. The process for changing the individual plan of care and individual budget.
    d. Recruitment and hiring of service workers.
    e. Management of service workers, including effectively directing, communicating, and problem-solving.
    f. Participant responsibilities in self-directed services, including the appeal process.
    g. Recognition and reporting of abuse, neglect, and exploitation.

Support Brokers have responsibility for training all of the participant's employees on the Policy on Reportable Incidents and ensuring that all incidents meeting the criteria of the Division's Notification of Incident Process are reported. Support Brokers must review employee time sheets and monthly Fiscal Management Service (FMS) reports to ensure that the individualized budget is being spent in accordance with the approved Individual Plan and Budget, and coordinate follow-up on concerns with the participant's case manager. Support Brokerage is funded through the participant's individual budget.

Support Brokerage is an optional service for a participant or legally authorized representative who self-directs services. If an EOR is struggling with self-directing responsibilities, the Division may require a Support Broker to be added to the person's plan of care in order to continue to self-direct. After a year of required support brokerage, the participant or representative may opt out of support broker services if he/she meets one of the criteria below and submits a formal request to opt out of Support Broker Services.

Criteria for Opting out of Support Broker Services includes the following, which is captured on an assessment tool completed by the case manager and approved by the Division:

1. Participants or their legal representatives who are self-directing through the Financial Management Service who demonstrate the ability to choose workers, coordinate the hiring of workers through the Financial Management Service provider, and coordinate the delivery of services with the FMS provider.
2. Participants or their legal representatives who have successfully self-directed services for one year with no concerns, including hiring, firing, training, scheduling workers and reviewing timesheets in a timely manner.

Scope and Limitations

Service is a 15-minute unit. There is annual cap of 320 units for both the Comprehensive and Supports Waivers. IBAs will not be increased to add this service.

Relatives can be a support broker to their related waiver participant, if they are a certified support provider and provide no other service to the participant on their plan. However, a parent/stepparent/legal guardian acting as a support broker cannot be reimbursed. They can be an unpaid support broker for the participant and are subject to the same qualification and monitoring requirements as paid support brokers.

All paid Support Brokers shall be free of any conflict of interest, including employment with a certified waiver provider or provision of any other Waiver service to the same participant. An Individual Support Broker hired by the participant shall only serve one participant, unless he/she is chosen to serve one additional sibling in the same household.

Individual Habilitation Training	Comprehensive Waiver Supports Waiver • May be self-directed	T2013	$29.66	hour

Individual Habilitation Training *(formerly Residential Habilitation Training)* is a specialized 1:1 intensive training service to assist a participant with the acquisition or improvement in skills not yet mastered that will lead to more independence and a higher level of functioning. Individual Habilitation Training services are for participants who live with unpaid caregivers or who need less than 24-hour paid supervision and support.

- Supports and training objectives are required and may include: adaptive skill development; assistance and training on activities of daily living; transportation safety and navigation; and building social capital and connections and hobby skill development for work on fine or gross motor skills.
- Objectives must be specific and measureable, and data must be tracked and analyzed for trends. Summary reports on progress or lack of progress must be given to the case manager and participant or guardian monthly. Objectives shall be re-written as needed when skills are learned or the objective is not yielding any progress.
- Services may be provided in the participant's home or in integrated settings with persons who do not have disabilities.
- Community access services cross the lifespan from childhood to adulthood. Supports may include facilitation of inclusion of the individual within a community group or volunteer organization; opportunities for the participant to join formal/informal associations and community groups; opportunities for inclusion in a broad range of community settings including opportunities to pursue social and cultural interests, choice making, and volunteer time.
- Transportation relating to the participant's training objective, such as trips into the community, shall be provided by the service provider and is included in the rate for the service.
- This service includes services not otherwise available through public education programs in the participant's local school district, including after school supervision, daytime services when school is not in session, and services to preschool age children.

Scope and Limitations

- Individual Habilitation Training is a 1:1 service with an hourly unit, which can be provided in 15-minute increments throughout the day but cannot be rounded to the nearest hour to bill. It is available to participants ages 0 through 21 on the waiver. Individual Habilitation Training services have a four (4) hour a day limit and units shall be approved based upon the participant's need and budget limit.
- Training can be done in a sixty (60) minute block of time, or a number of programs with specific time frames for each program, so a total 60 minutes in one day can be completed.
- Providers are responsible for both formal and informal training opportunities. The schedule must be individualized and the training objective must be meaningful. Progress on objectives shall be reported to the case manager and participant or guardian monthly.
- Relative providers (excluding parents/stepparents) may provide this service.
- For participants through age 21, Individual Habilitation Training services cannot duplicate or replace services covered under IDEA and services cannot be provided during school hours.
- Individual Habilitation Training may not be used with Special Family Habilitation Home services and also cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency.

Provider Qualifications Note

Individual Habilitation Training providers within one year of being certified in this service, and annually thereafter, must successfully complete at least eight (8) hours of continued education in any of the following areas: specific disabilities or diagnosed conditions related to the population he/she serves, in writing measurable objectives, gathering using data to develop better training programs, or training modules posted by the Division.

Occupational Therapy	Comprehensive Waiver Supports Waiver ABI Waiver	97532 97150	Individual Group	$17.02 $15.96	15 minute Session

Occupational Therapy services consist of the full range of activities provided by a licensed occupational therapist. Services include assessing needs, development a treatment plan, determining therapeutic intervention, training and assisting with adaptive aids. Occupational Services through the waiver can be used for maintenance and the prevention of regression of skills. The units must be prior authorized and must be prescribed by a physician. Medicaid State Plan Occupational Services are limited to restorative therapy. Services are available for a participant age 21 and older. Services are provided under the state plan when they are restorative. Maintenance therapy may be provided under the waiver. These services are uniquely coded. Edits to MMIS prohibit both restorative and maintenance therapy from being billed on the same day. Relative providers shall not provide this service.

Service is available as an individual 15 minute unit or as a group session unit which requires a minimum of 30 minutes in service in order to bill. If the service order looks restorative in nature, a Third Party Liability Form may be required.

Personal Care	Comprehensive Waiver Supports Waiver ABI Waiver • May be self-directed	T1019	$3.85	15 minute unit

A range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Personal care services may be provided on an episodic or on a continuing basis. Health-related services that may be provided includes care relating to medical or health protocols, medication assistance or administration, and range of motion exercises. Health related services may be provided after staff are trained by the appropriate trainer or medical professional and documentation of training is included in the staff person's personnel file.

Such assistance may include assistance in performing activities of daily living (ADLs-bathing dressing, toileting, transferring, maintaining continence) and instrumental activities of daily living on the person's property (IADLs-more complex life activities, e.g. personal hygiene, light housework, laundry, meal preparation exclusive of the cost of the meal, using the telephone, medication and money management).

Transportation costs are not included as part of this service.

The participant must be physically present. Personal care shall be provided in the participant's home or on their property. If the individual providing this service is not employed and supervised by an agency, then the participant is responsible for supervising the individual and may coordinate monitoring of the service with his/her case manager.

Scope and Limitations

This service is available to all ages and is a 1:1 service. There is no cap on the Supports Waiver. On the Comprehensive Waiver, units shall be approved based upon need, fit within the person's assigned budget, with a maximum annual cap of 6000 units for persons in a non-residential or SFHH service setting.

For participants in a residential or SFHH service, personal care units may be approved up to 7280 units a year when the participant needs ongoing supervision but cannot attend a day service due to a medical or health condition that prohibits or limits attendance at a congregate day program upon verification of need and approval of the Division.

Personal care services are included in Companion, Child Habilitation, Individual Habilitation Training, Supported Living, Adult Day Services, Community Integration, Prevocational, Supported Employment, Special Family Habilitation Home, and Residential Habilitation services; therefore, Personal Care cannot be provided in conjunction with those services and if provided on the same day, service times must not overlap.

Personal care cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency. The amount of personal care services prior authorized by the Division for the legally responsible individual will be based upon

individual extraordinary care needs as specified in the individualized plan of care and other assessments.

Personal care is not covered as a stand-alone service through the Medicaid state plan, but it is available through home health with a physician's order. A home health provider typically provides services from 8 am to 5 pm. Being a rural state, many Wyoming communities do not have home health providers to serve their community. Those that do, often do not have enough employees to meet the extensive needs of some waiver participants. Waiver participants who need personal care services must utilize providers that can provide the type, amount and flexible hours of services deemed most appropriate for the participant. The waiver service allows the team to find and utilize providers who can best meet the participant's needs.

Relative providers

Any relative providers may provide this service but with certain restrictions:

- For minor children (under age 18) parents, stepparents or guardians, may only provide this service if they are either a certified provider and form a limited liability company (LLC) or they work for a certified provider and if the child meets the extraordinary care criteria listed below.
- Parents, Stepparents, Spouses, or legally responsible individuals may not provide this service or any other service through self-direction.
- For adult participants (age 18 and older) guardians may not provide any personal care service. Parents/stepparents may provide this service if they are either a certified provider and form a limited liability company (LLC) or they work for a certified provider
- For any relative providers residing in the same household as the waiver participant, personal care provided by the relative provider in the home shall be for extraordinary care only, as defined by the Division, and cannot exceed four (4) hours per day per participant. It is expected that for those participants living with their families, that the family members will contribute natural support and supervision, similar to how families function. Additional units needed beyond 4 hours a day require additional documentation and shall only be approved by the Division's Extraordinary Care Committee.
- The amount of units approved for a relative provider will depend on the individual needs of the participant and *may* range up to no more than four (4) hours per day with those participants requiring more intensive supports, i.e., total assistance with toileting, bathing, feeding, non-ambulatory, etc… as the justification for the number of hours needed per day. The case manager shall submit specific justification regarding the support needs with the plan of care.
- For personal care provided to participants under age 18 by a legally responsible individual, payment shall only be authorized for extraordinary care services provided by the legally responsible individual provider as documented in the plan of care and align with the assessed needs of the participant which show the need for extraordinary care.

Extraordinary care cases shall meet the following criteria:

1. The participant's Adaptive Behavior Quotient is 0.35 or lower on the Inventory for Client and Agency Planning (ICAP) assessment; and either b or c
2. The participant needs assistance with Activities of Daily living (ADLs) or Instrumental Activities of Daily Living (IADLs) exceeding the range of expected activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization. (Example: a 12 year old needing assistance with dressing and bathing, whereas the average 12 year old does not.); or
3. The participant requires care from a person with specialized medical skills relating to the participant's diagnosis or medical condition as determined appropriate by the participant's medical professional and the Behavioral Health Division.

If a legally responsible individual is providing personal care to his/her ward, the plan of care shall be developed and monitored by a case manager without a conflict of interest to the legally responsible individual provider or to the participant, which means the case manager shall not be employed by or related to the provider or the participant (i.e. sibling, child, grandparent, aunt, uncle, or other parent/step-parent, cousin, step family, or the participant's guardian), to ensure the provision of services is in the best interest of the participant.

The plan shall document that services do not duplicate similar services, natural supports, or services otherwise available to the participant.

Physical Therapy	Comprehensive Waiver Supports Waiver ABI Waiver	97110 97150	Individual Group	$20.83 $15.96	15 minute Session

Physical Therapy services consist of the full range of activities provided by a licensed physical therapist. This service assists individuals to preserve and improve their abilities for independent function such as range of motion, strength, tolerance, and coordination. It may also prevent, insofar as possible, irreducible or progressive disabilities through the use of assistive and adaptive devices, positioning, and sensory stimulation. Services are available for a participant age 21 and older. Services through the waiver can be used for maintenance and the prevention of regression of skills. The units must be prior authorized and must be prescribed by a physician. State Plan Physical Services are limited to restorative therapy. Services provided under the state plan must be utilized to the extent they are allowed. The state plan covers some visits each year and the cap can be exceed with justification from a qualifying medical professional when they are restorative. These services are uniquely coded. Edits to MMIS prohibit both restorative and maintenance therapy from being billed on the same day. Relative providers shall not provide this service.

Service is available as an individual 15 minute unit or as a group session unit which requires a minimum of 30 minutes in service in order to bill. If the service order looks restorative in nature, a Third Party Liability Form may be required.

Prevocational	Comprehensive Waiver Supports Waiver ABI Waiver	T2015 T2015 TF T2015 TG	Basic Care Intermediate Care High level of care	$2.70 $3.51 $5.40	15 minute unit

Prevocational services are services designed to create a path to integrated community based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Prevocational services should enable each individual to attain the highest level of work in the most integrated setting and with the job matched to the individual's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Services provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to future employability in paid employment in integrated community settings.

- Services include teaching concepts such as compliance, attendance, task completion, problem solving, interpersonal relationships, and safety. Services are not job-task oriented, but aimed at generalized results.
- Service activities must be reflected in the participant's plan of care and are directed to habilitative, rather than employment objectives.
- Services may be furnished in a variety of locations in the community and are not limited to provider facilities.
- Prevocational services may be provided at a volunteer worksite or mentorship locations for the purpose of teaching job preparedness for a specific type of work.
- Participation in prevocational services is not a required pre-requisite for individual or small group supported employment services furnished under the waiver.
- Prevocational services are time-limited and should not exceed 12 consecutive months. In some cases, an additional 12 months may be approved by the Division in subsequent years with submission of an approved employment plan (through vocational rehabilitation, school district, or the waiver) and upon review of active progress made the prior year on finding employment opportunities, increasing work skills, time on tasks, or other job preparedness objectives.
- A monthly objective must be included in the provision of services relating to either volunteering, mentoring, increasing involvement with community members, improving communication with community members, and accessing other resources to further employment development, such as curriculum based trainings, online information modules on careers, or resources from the community or other agencies that will potentially prepare the participant to a job outside of the provider facility.
- If no progress on prevocational objectives and the employment plan occur, the Division may not

approve the service in subsequent years and other waiver services may be accessed to meet the supervision and support needs of the participant.
- Services are reimbursed based upon the participant's level of service need.
- Transportation is included in the reimbursement rate.

A Participant receives a tiered service approved in the plan of care based upon need, according to the following tiers descriptions:

Basic Level of Care
Levels 1 and 2 on the Level of Service Need grid will generally be in this tier. Service tier requires limited staff supports and personal attention to a participant daily due to a moderately high level of independence and functioning. Behavioral needs, if any, can be met with medication or informal direction by staff. The person may have periods of time with indirect staff supervision where staff are onsite and available through hearing distance of a request.

Intermediate Level of Care
Levels 3 and 4 on the Level of Service Need grid will generally be in this tier. Service tier requires full-time supervision with staff available on-site within line of sight due to significant functional limitations, medical and/or behavioral needs. Behavioral and medical supports are not generally intense and can be provided in a shared staffing setting. Regular personal attention is given throughout the day for personal care, reinforcement, community or social activities.

High Level of Care
Levels 5 and 6 on the Level of Service Need grid will generally be in this tier. Service tier requires full-time supervision with staff available on-site within absolute line of sight and frequent staff interaction and personal attention for significant functional limitations, medical and/or behavioral needs. Support and supervision needs are moderately intense, but can still generally be provided in a shared setting unless otherwise specified in the plan of care. Frequent personal attention given throughout the day for reinforcement, positive behavior support, personal care, community or social activities.

Scope and limitations

Prevocational service is a habilitation service and objectives must be actively taught, with progress reported to the case manager, participant and guardian monthly. Individuals participating in prevocational services may be compensated in accordance with applicable Federal laws and regulations; however, waiver funding is not available for the provision of vocational services delivered in facility-based or sheltered work settings, where individuals are supervised for the primary purpose of producing goods or performing services.

Service is available for participants ages 21 and older who are no longer receiving school services.

Documentation must be maintained in the provider and case manager's file for each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Provider Qualifications Note

Within one year of being certified in this service, one (1) staff person working in this services must be certified in a nationally recognized supported employment curriculum and demonstrate that a portion of their time each month is spent training direct care staff on exploring employment interests, working on job readiness skills, or other employment related activities with participants.

Residential Habitation	Comprehensive Waiver ABI Waiver • Res Hab Shared Living may be self-directed on Comprehensive Waiver or ABI waiver only	T2016 UA level 1 T2016 UC level 2 T2016 level 3* **After July 1 no U8 modifier* T2016 U7 level 4 T2016 U6 level 5 T2016 U5 level 6	$ 80.65 $ 88.77 $119.31 $142.00 $187.40 $323.59	daily

Residential Habilitation services are individually-tailored supports for a waiver participant that assists with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential Habilitation includes personal care, protective oversight and supervision.

- Residential Habilitation services are reimbursed using a daily unit based upon the level of service need of the participant, where the participant needs some level of ongoing 24 hour support by a provider on site.
- Services can be furnished in a group home, shared living arrangement, host home, or in the participant's home.
- Residential Habilitation may be furnished in a home owned or leased by a provider or the participant.
- For Residential Habilitation delivered through self-direction as Shared Living- This service may be self-directed for an individual in a shared living setting, where the participant or participants own or lease the residence from an entity that is not a certified waiver provider. The employee hired through self-direction may serve up to 3 people in res hab-shared living at the same time, but can serve no other people in a residential habilitation service.
- Provider owned or leased facilities where Residential Habilitation services are furnished must be compliant with the Americans with Disabilities Act.
- Transportation between the participant's place of residence, other service sites, or places in the community is included in the rate.
- Residential habilitation services must be furnished in living arrangements subject to §1616(e) of the Social Security Act (the Keys Amendment), and the standards for such services must meet Chapter 45 of the Wyoming Medicaid Rules for facility standards, including assuring that the living arrangement is homelike rather than institutional in character.

Tiered Levels

A Participant receives a tiered service approved in the plan of care based upon need, according to the following tiered descriptions. Tier levels for this service align with the assessed Level of Service Need for the participant and the expectations of the service as specified in the definition. Participants with a score in between two levels (such as a 3.5 can choose either tier (either level 3 or 4), whichever is more appropriate for their needs and fits within the IBA. All supervision and supports delivered must align with the participant's plan of care.

Level 1 –Due to a high level of independence and functioning and no significant behavioral or medical issues, this tier requires staff available on-site and meeting periodically with the participant during awake hours on each day billed to provide general supervision, support, monitoring, training, and on-call 24 hour support.

Level 2- Due to a moderately high level of independence and functioning and few behavioral or medical issues, if any, that require minimal staff support, monitoring, or personal care, this tier requires staff available on-site within close proximity to the person's residence at all times, meeting periodically with the participant during awake hours on each day billed to provide general supervision, support, monitoring, training and on-call 24 hour support.

Level 3- Due to moderate functional limitations in activities of daily living and possible behavioral support needs, this tier requires staff available on-site within hearing distance in the same residence as the participant and meeting periodically with the participant on each day billed for general supervision, support, personal care, positive behavior support, monitoring, training and staff support through the

night in the residence or in a nearby office.

Level 4- Due to significant functional limitations, medical and/or behavioral support needs, this tier requires full-time staff to be on-site in the person's residence when the person is in this service, with regular personal attention given throughout the day for training, personal care, reinforcement, positive behavior support, community or social activities. Behavioral and medical supports are not generally intense and can be provided in a shared staffing setting. There must be staff support in the residence through the night.

Level 5- Due to significant and somewhat intensive functional limitations, medical and/or behavioral support needs, this tier requires 1 or more full-time staff support to be on-site and in line of sight during most awake hours when the person is in this service, with frequent personal attention given throughout the day for training, personal care, reinforcement, community or social activities. Behavioral and medical supports or personal care may be somewhat intense but service may be provided in a smaller shared staffing setting. Overnight expectations are stipulated in the plan of care.

Level 6-Due to the high medical, behavioral and/or personal care needs, this tier requires frequent personal support and supervision with full-time staff on-site and within line of sight during most awake hours. The expectation is that the participant shall receive the attention of at least one to two caregiver(s) as specified in the plan of care. Staffing ratios during the day and night must be kept as approved by BHD in the plan of care.

Scope and limitations

The participant must be age 18 or older to use this service. The provision of Residential Habilitation services includes personal care needs, so plans of care are not approved that include both residential services and personal care services at the same time of day. If personal care is on the plan during the day, because the person did not want or cannot attend a day programs due to medical needs, the service times for personal care and residential habilitation may not overlap.

Since residential habilitation is paying for support to an individual who needs support 24 hours a day, the provider must be in the residence of the participant providing service during both awake and sleeping time for a minimum of 8 hours in a 24 hour period (from 12:00am-11:59pm) for the provider to be reimbursed.

Family visits and trips are encouraged. The provider will be allowed to be reimbursed on the day the participant returns home from a trip.

Payment is not made, directly or indirectly, to members of the participant's immediate family, except as provided in Appendix C-2 of the waiver application. Payment is not be made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for Residential Habilitation is specified in Appendix I-5 of the waiver application.

Relative providers may provide all components of this service as defined with the following limitations:

- A relative (excluding parents/stepparents/legal authorized representatives) may provide this service to the participant while residing in the same residence as the participant.
- A relative who is a parent/stepparent, may provide this service as long as they are either a certified provider and form an LLC or they are an employee of a certified provider. They may provide this service as defined but shall not live or reside in the same residence as the participant.

Targeting Criteria to receive this service

Waiver participants not receiving 24-hour residential services, who are at significant risk due to extraordinary needs that cannot be met in their current living arrangement, may request 24-hour Residential Habilitation services if the participant meets one of the following targeting criteria:

- A substantial threat to a person's life or health caused by homelessness or abuse/neglect that is either substantiated by Department of Family Services or corroborated by the Behavioral Health Division or Protection & Advocacy Systems, Inc.
- Situations where the person's condition poses a substantial threat to a person's life or health, and is documented in writing by a physician.
- Situations where a person has caused serious physical harm to him or herself or someone else in the home, or the person's condition presents a substantial risk of physical threat to him or herself

or others in the home.

- Situations where there are significant and frequently occurring behavior challenges resulting in danger to the person's health and safety, or the health and safety of others in the home.
- Situations where the person's critical medical condition requires ongoing 24-hour support and supervision to maintain the person's health and safety.
- Loss of primary caregiver due to caregiver's death, incapacitation, critical medical condition, or inability to provide continuous care.

Respite	Comprehensive Waiver Supports Waiver	T1005	$3.49	15 minute
	ABI Waiver	S9126	$167.52	Daily
	• Maybe self-directed			

Respite Service is intended to be utilized on a short-term, temporary basis for an unpaid caregiver or non-CARF residential habilitation provider to provide relief from the daily burdens of care. Respite service includes assistance with activities of daily living (ADL), medication assistance if needed, and supervision. Respite cannot be used for childcare/daycare purposes while the primary caregiver is working. Respite cannot be used during services otherwise available through public education programs including education activities, after school supervision, daytime services when the school is not in session, or services to preschool age children.

It may be provided in the caregiver's home, the provider's home, or in community settings. Respite can only be provided for up to two people at the same time or up to three if members are in the same family and live in the same household (as long as all participants can be safely supported by one provider or unless the participant's plan of care requires an intensive support level).

A special family habilitation home (SFHH) provider may use respite from another provider for a child receiving services in their home when they need a temporary break. The SFHH would not be the provider of respite services to the child nor be paid to provide respite for the child who is living with them.

Scope and Limitations:

Respite is reimbursed as a 15-minute unit or a daily rate.

There is no cap on the Supports waiver. On the Comprehensive Waiver, the total number of 15 minute units available for respite per plan year is 5,000. On the ABI waiver, the Respite cap is still 1,664 (subject to change with an amendment in July 2015). The combined use of daily and 15-minute service cannot exceed an average of 24 hours a week of service over the plan year, which is equivalent to 1250 hours a year.

- Any use of respite over 9 hours a day must be billed as a daily unit.
- Approved amount of service is based upon the participant's need and budget limit, not to exceed 5000 units per plan year on Comprehensive waiver.
- Services provided must be provided as relief of the primary caregiver, should primarily be episodic in nature, and may not be used when parents or primary caregivers are working.
- Relative providers (excluding parents/stepparents) may provide this service.
- Respite services cannot be provided during the same time period as other waiver services, which is subject to audit by the Program Integrity Unit within the Single State Medicaid Agency.

A respite service provider or provider staff providing respite services:

- Cannot serve more than two waiver participants or up to three, if participants are in the same family and live in the same household (as long as all participants can be safely supported by one provider or unless the participant's plan of care requires an intensive support level).
- May also provide supervision to other children under the age of 12 or other individuals requiring support and supervision, but
- Must limit the total combined number of persons they are providing services to at a given time (both participants and other children under the age of 12 or other individuals requiring support and supervision) to no more three persons unless approved by the Division
- Must adhere to the supervision levels identified in each participant's plan of care

Respite services cannot not take the place of residential or day habilitation services. Transportation is included in the rate.

While the primary caregiver is working, a different service or support must provide the supervision needed instead of respite, such as Child Habilitation, Companion services, or natural supports. Respite services shall accommodate the needs of the participant. The respite site and services shall match the identified needs of the participant and family.

A respite provider cannot provide respite services to adults and children at the same time except to participants who are 18 to 20 years of age who may receive respite services with adults. In exceptional cases, such as when participants are members of the same family, respite may be provided to adults and children at the same time with Division approval.

Self-directed Goods and Services	Comprehensive Waiver Supports Waiver ABI Waiver • **Only available through self-direction** and only if one direct care service is being self-directed as well	Annual Cap of $2000	Prior approval from Division needed	Cost varies per event

Goods and services are services, equipment, and supplies that provide direct benefit to the participant and support specific outcomes in the individual plan of care. The service, equipment or supply must:

1. Reduce the reliance of the participant on other paid supports, or
2. Be directly related to health or safety of the participant in the home or community, or
3. Be habilitative and contribute to a therapeutic objective, or
4. Increase the participant's ability to be integrated into the community, or
5. Provide resources to expand self-advocacy skills and knowledge.

Subject to prior approval by the Division, Goods and Services may include:

- Equipment not otherwise available through the specialized equipment waiver service
- Devices, aids, controls, supplies, or household appliances which enable individuals to increase the ability to perform activities of daily living or to perceive, control, or communicate with the environment and/or community in which s/he lives. Service includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Service includes vehicle modifications but does not include items of direct medical or remedial benefit to the individual. All items must meet applicable standards of manufacture, design, and installation.
- Transportation provided by family members (excluding parents, step-parents, guardians, or spouses per Wyoming State Statute), friends, and other licensed drivers for using non-agency vehicles to transport the person to services and activities specified in the person's individual plan of care unless the service includes transportation. The unit of service is one mile. The rate may not exceed the current state rate for mileage reimbursement and cannot include medical transportation covered by the Medicaid State Plan.
- Home modifications not otherwise allowed in the Environmental modification waiver service. Allowable modifications may include physical adaptations which are necessary to ensure the health, welfare, and safety of the individual in the home, enhance the individual's level of independence, or which enable the individual to function with greater independence in the home.
- Camps - May cover cost of the participant attending a camp, and in some cases, an attendant to accompany the person to a camp that he/she could not attend alone and additional staffing was not available at the camp to ensure the person's health and safety.
- Consultation, evaluation and training, and/or a written document that evaluates and identifies the participant's strengths, needs, current availability and potential capacity of natural supports, and the need for service and financial resources, if appropriate. As appropriate for the participant, a consultation shall include participant preferences, health status, medications, conditions and treatments, functional performance, including Activities of Daily Living (ADLs), level of assistance needed, and assistive devices used and/or needed. Behavior and emotional factors, including pertinent history, coping mechanisms, and stressors. Cognitive functioning, including memory, attention, judgment, and general cognitive measures. Environmental factors, including architectural, transportation, other barriers. Social supports and networks, including natural supports. Financial factors, including guardianship or conservatorships, or entitlements that influence the array of

supports and services that are needed.

Consultations and evaluations may be warranted based upon a specific disability, diagnosis, behavior concern, or medical condition relating to the disability. Family members and the person's environment may be involved in the consultation and training, which will help the person increase their health and safety, minimize the use of paid supports, and reduce the likelihood of institutionalization. This consultation and evaluation shall be used by the family and participant's team to better provide both paid and unpaid supports for the participant.

Scope and Limitations

Self-Directed Goods and Services have a $2,000 annual limit and typically include any device which is not currently allowed under Specialized Equipment. All goods and services must be prior authorized by the Division and cannot be available through Specialized Equipment or Environmental Modifications on the waiver as specified in Chapter 44 of the Medicaid Rules. The Division may approve requests above the limit if the request meets the specified criteria.

Criteria for approving requests above the limit shall include goods or service needs that are due to:

- Unmet needs because of aging out of school
- Documented unavailability of vocational rehabilitation services
- Increasing health concerns that require more services
- Increasing behavioral concerns that require more intervention
- Health needs of unpaid caregivers who cannot continue the historical level of support.

Self-directed goods and services cannot be used for personal care items (toiletries or things used for daily hygiene), homemaking, clothing or bedding. Electronic technology equipment requests that meet the criteria of the service definition, such as a computer, iPad, or game system may only be purchased only once every five (5) years and must have prior approval from the Division.

Equipment purchases have a cap of $2,000 and cannot include any item covered under the specialized equipment waiver service. If an item needed exceeds that amount, the team may request an exception to the cap through the ECC. The Division may require an assessment for an equipment purchase by a Certified Specialized Equipment (CSE) professional. Assessment is funded as a part of the $2,000 cap.

Electronic technology devices are only allowed once every five (5) years and like items cannot be purchased during those five (5) years. There are no exceptions. The Division shall limit the purchase of any general item purchase and only allow the purchase of an iPad or other electronic devices, if recommended by CSE professional.

Certain items may not be covered, such as computers, bikes, or furniture, if the item does not meet the criteria of the service definition. A list is not included because each situation is different depending on the person's diagnosis, condition, and assessed needs.

Goods and Services approved by the Division only cover the costs for the actual device. It does not include any insurance. If the person wants insurance, he/she must purchase it on separately.

This service is only available for participants self-directing at least one direct care service through the Fiscal Employer Agent FMS option, (PPL). This service may be provided by a relative (excluding parents/stepparents). This service may not duplicate any Medicaid State Plan service.

Modifications to a residence, that are not covered under the environmental modification service, may be approved if the cost of such modifications does not exceed the value of the residence before the modification. Covered modifications of rented or leased homes shall be those extraordinary alterations that are uniquely needed by the individual and for which the property owner would not ordinarily be responsible. Service does not include adaptations or improvements to the home, which are of general utility and are not of direct medical or remedial benefit, nor adaptations that add to the total square footage of the home or are covered as an environmental modification.

All Goods and Services, Specialized Equipment and Environmental Modifications are prior authorized by the Division. Items are tracked in the electronic plan of care system, EMWS. Preapproved by the BHD specialists. All documentation of these items are kept within the EMWS from one plan year to the next, so all BHD specialists may review why this has been requested before.

Skilled Nursing	Comprehensive Waiver Supports Waiver ABI Waiver	T1002	$18.01	15 minute unit

Skilled Nursing services are medical care services delivered to individuals with complex chronic and/or acute medical conditions, which are performed within the Nurses' scope of practice as defined by Wyoming's Nurse Practice Act, which includes the application of the nursing process including assessment, diagnosis, planning, intervention and evaluation and the administration, teaching, counseling, supervision, delegation, and evaluation of nursing practice and the execution of the medical regimen. The services must require a level of expertise that is undeliverable by non-medical trained individuals. The delivery of Skilled Nursing services is limited to those individuals who possess a valid and unencumbered license issued by the Wyoming State Board of Nursing.

Skilled Nursing services are available on the Medicaid State plan by home health providers, therefore the waiver service is an extension of the Medicaid State plan. Skilled Nursing services may be used when the state plan services have been exhausted, are not available in the person's area, not available due to services denied by the home health provider, or the hours of need for the service are not available by the home health provider. Services approved in the plan of care that must be within the scope of the State's Nurse Practice Act.

A billable skilled nursing service unit is considered to be a service that is provided up to 15 minutes and that involves one-on-one direct patient care.

Scope and Limitations

Providers cannot be reimbursed for skilled nursing services that do not include direct patient care or services that do not include skilled nursing duties. For example, skilled nursing providers cannot be reimbursed for watching television with a participant, transportation to and from doctor appointments, time spent charting, time spent in waiting room with participant, or time spent completing paperwork.

Skilled Nursing services are available on the waiver if a person cannot get the services through home health on the Medicaid State Plan, which requires that skilled nursing services be provided if a minimum of two (2) medically necessary services are needed. A Third Party Liability Form is required.

Relative providers shall not provide this service.

Skilled nursing may not be used if trained provider staff are able to provide the service, such as medication assistance or support for a medical appointment, unless the participant has a chronic or acute medical condition that requires a skilled nurse's direct support.

Skilled nursing on the waiver may be provided by provider agencies and independent nurses as long as they meet the provider qualifications. The Wyoming Medicaid State Plan requires that skilled nursing services be provided by home health agencies that provide a minimum of two medically necessary services.

Special Family Habilitation Home	Comprehensive Waiver only	T2033	$130.40	Daily

Special Family Habilitation Home consists of participant specific, individually designed and coordinated training within a family (other than biological or adoptive parents) host home environment.

This service is only available to children who are already receiving this service in an approved plan of care. The service is not open to newly enrolled participants. The Division will keep the service on the waiver to serve current SFHH placements until another residential option is available to the child, subject to involvement from the Department of Family Services, Department of Education, Office of the Attorney General and the Wyoming Department of Health. For participants ages 18 and older, Residential Habilitation Services will be available to a participant who meets the targeting criteria for the service. For participants ages 0 through 17, the Division will work with the Department of Family Services and the Department of Education in order to help the child receive residential services if they are determined to be the last resort for the minor child. The Division does not have the authority to remove children from the family home and foster care services are paid for by the Department of Family Services. In some instances, the Department of Education will pay for residential services as well. If the minor is on the

waiver, the waiver will provide services to the provider or family to help support the participant but not cover the residential habilitation service costs.

- This service is intended for children birth through 20 years of age.
- The provider is the primary caregiver and assumes 24-hour care of the individual.
- This service cannot be used in conjunction with Individual Habilitation Training services.
- The provision of special family habilitation home services includes personal care needs, so plans of care are not approved that include both residential services and personal care services.
- Since this service is paying for support to an individual who needs support 24 hours a day, the provider must be in the residence of the participant providing service during both awake and sleeping time for a minimum of 8 hours in a 24 hour period (from 12:00am-11:59pm) for the provider to be reimbursed. Family visits and trips are encouraged. The provider will be allowed to be reimbursed on the day the participant returns home from a trip.
- Relative providers (excluding parents/stepparents) may provide this service.
- Providers are responsible for both formal and informal training opportunities. The schedule must be individualized and the training objective must be meaningful. Progress on objectives shall be reported to the case manager monthly.
- Transportation is included in the reimbursement rate.

Specialized Equipment	Comprehensive Waiver Supports Waiver ABI Waiver	T2029 NU T2029	New Repair	PA#	Per event

Specialized equipment includes:

1. Devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living;
2. Devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live;
3. Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;
4. Such other durable and non-durable medical equipment not available under the Medicaid state plan that is necessary to address participant functional limitations; and,
5. Necessary medical supplies not available under the Medicaid state plan or other insurance held by the participant. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

If the participant has an IEP or IFSP, the case manager will be required to submit a copy of that document, along with documentation as to why the equipment is not sent home with the participant or a reason why the equipment is necessary at home but not at school.

Scope and Limitations

Specialized equipment shall meet at least three of the following criteria and is subject to BHD approval:

1. Be functionally necessary, and
2. Be necessary to increase the ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which the person lives, or
3. Be necessary to enable the participant to function with greater independence and without which the person would require institutionalization, or
4. Be necessary to ensure the person's health, welfare, and safety.

Allowable items and limitations of this service are found in Medicaid Rule Chapter 44.

Relative providers (including parents/stepparents) may provide this service with the following requirements:

- They are a certified Medicaid Waiver Specialized Equipment Provider; and
- Do not impose a mark-up to the total cost of the equipment when providing this service to their relative (unless they operate a non-profit corporation); and
- Receive at least one other bid from another provider to ensure cost effectiveness.

The individualized plan of care shall reflect the need for equipment, how the equipment addresses health, safety, or accessibility needs of the participant or allows them to function with greater independence, and specific information on how often the equipment is used and where it is used. Criteria for approval is outlined in Chapter 44 of the Wyoming Medicaid Rules. The case manager shall check with Medicaid, Medicare, and/or a participant's other insurance carrier to see if the requested equipment is covered under their plans. A Third Party Liability Form may be required. Waiver funds are a payer of last resort. The Medicaid waivers can only pay for what is functionally necessary, in other words, no convenience items.

Service Caps

Equipment purchases have an annual cap of $2,000. If an item needed exceeds that amount, the team may request an exception to the cap through the ECC. The Division may require an assessment for specialized equipment needs by a Certified Specialized Equipment (CSE) professional. Assessment is funded as a part of the $2,000 cap.

Electronic technology devices are only allowed once every five (5) years and like items cannot be purchased during those five (5) years.

Speech, Language and Hearing Services	Comprehensive Waiver Supports Waiver ABI Waiver	92507 92508	Individual Group	$50.34 $19.32	Session

Speech, Hearing and Language services consist of the full range of activities provided by a licensed speech therapist. Services include screening and evaluation of participants with respect to speech function; development of therapeutic treatment plans; direct therapeutic intervention; selection, assistance, and training with augmentative communication devices, and the provision of ongoing therapy. Services are available for a participant age 21 and older. Services through the waiver can be used for maintenance and the prevention of regression of skills. The units must be prior authorized and must be prescribed by a physician. Services are provided under the Medicaid state plan when they are restorative. Maintenance therapy may be provided under the waiver. These services are uniquely coded. Edits to MMIS prohibit both restorative and maintenance therapy from being billed on the same day. Relative providers shall not provide this service. A minimum of 45 minutes of service per session must be provided in order to bill. If the service order looks restorative in nature, a Third Party Liability Form may be required.

Subsequent Assessment	Comprehensive Waiver Supports Waiver ABI Waiver	T2024TS		PA#	Per event

Subsequent assessments are provided as part of ongoing case management and will include the necessary collaboration of professionals to assess the needs, characteristics, preferences and desires of the waiver participant. Case managers shall initiate and oversee subsequent assessments, regardless of payment source. These include the psychological assessment, if needed for continued eligibility and any other approved assessments that are necessary to determine the participant's needs and are not available through the Medicaid State plan. Psychological evaluations for eligibility are no longer required every five years and will only be approved because of a significant change in the participant and with prior approval by the Division. Any assessments must be prior authorized by the Division.

Supported Living	Comprehensive Waiver Supports Waiver ABI Waiver • May be self-directed	T2017 T2017 HQ T2017 UP T2031	Individual Group of 2 Group of 3 Day unit (may serve 3)	$8.27 $4.14 $3.17 $88.76	15 minute 15 minute 15 minute Daily

Supported Living services assist a participant to live in a home or apartment leased by the participant or guardian, or in the family home when the participant requires a range of community-based support to live as independently as possible. Supported Living Service provides individually tailored supports to assist with the acquisition, retention, or improvement in skills related to living successfully in the

community. Supported Living Services are based on need and include assisting with common use of the community's transportation system; teaching the use of police, fire, and emergency assistance; performing routine household activities to maintain a clean and safe home; assistance with health issues, medications, and medical services; managing personal financial affairs; building and maintaining interpersonal relationships; participating in community life, and 24-hour emergency assistance.

- Supported Living Service includes personal care, therefore personal care services cannot be added as a separate service on the plan of care.
- Participants must be at least 18 years old to receive Supported Living Service.
- Relative providers may provide all components of this service with the following limitations:
  - A relative (excluding parents/stepparents/legal authorized representatives) may provide this service to the participant while residing in the same residence as the participant.
  - A relative, who is a parent/stepparent, may provide this service as long as they are either a certified provider and form an LLC or a corporation or become an employee of a certified provider. They may provide this service as defined but shall not live or reside in the same residence as the participant.

Scope and limitations

- Supported Living Service daily rate is based on 7 hours of service a day and a provider must provide a minimum of 4 hours of documented service per calendar day for reimbursement. One staff or provider can be reimbursed for up to 3 participants during one period of time.
- Supported Living Service can also be billed at a 15-minute unit rate for a maximum of 5,400 units per plan year for services provided to a group up to two or three participants, or 3,900 15-minute units per plan year provided to an individual participant.
- Supported living is a habilitation service, which means training on objectives is expected as part of the provision of services and objective progress must be reported to the participant, guardian, and case manager monthly.
- The plan of care must identify either the daily unit or the individual or group 15-minute unit, based on the participant's need. Both the daily unit and the 15 minute unit may be on the participant's plan of care but cannot be used on the same day.
- Transportation is included in the reimbursement rate for this service.

Supported Employment ***(Individual & Small Group)***	Comprehensive Waiver Supports Waiver ABI Waiver • Individual Supported Employment may be self-directed	T2019 Individual T2019 UQ Group	$6.78 $2.70	15 minute units

Employment Pathway-Service Overview

This waiver offers various employment support services to support and assist a participant (ages 18+) who, because of their disability, needs intensive support to find and maintain a job in competitive, integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by an individual without a disability. The outcome of using the employment pathway of support services is to help a participant find and maintain a job that meets personal and career goals.

A range of supported employment services are available with varying levels of support and intensity to assist the participant in attaining and maintaining the highest level of paid, community integrated employment. Consistent with the *Olmstead* decision and with person-centered planning, a participant's plan of care regarding employment services shall be constructed in a manner that reflects individual choice and goals relating to employment and ensures provision of services in the most integrated setting appropriate. Pathway services include Prevocational Services, Employment Discovery and Customization, Small Group Supported Employment, Individual Supported Employment, Supported Employment Follow Along, and Transportation services.

Small Group Supported Employment

Small group supported employment services may be provided under a group rate for groups ranging from 2 to 9 persons. Group employment for groups larger than 9 people will not be reimbursed by the waiver. Small Group Supported Employment services consist of intensive, ongoing support that enable a

participant, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of his/her disability, need supports to perform in a regular work setting, including mobile work crews or enclaves. Services are conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Services include activities needed to sustain paid work by a participant, including supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations; supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Objectives must be identified in the participant's plan that supports the need for continued job coaching with a plan to lessen the job coaching over time, if possible. The job coach must be in the immediate vicinity and available for immediate intervention and support. Small group supported employment can include employment in community businesses or businesses that are part of a provider organization.

Individual Supported Employment

Individual Supported Employment services are the 1:1 supports available to a participant who, because of their disability, needs intensive, sometimes on-going support, to obtain and maintain an individual job in competitive or customized employment, self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by an individual without a disability.

Services are conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Services include activities needed to sustain paid work by a participant, including supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations; supervision and training required by participants receiving waiver services as a result of their disabilities, but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Objectives must be identified in the participant's plan that supports the need for continued job coaching with a plan to lessen the job coaching over time, if possible. Individual Supported Employment must be provided in a community employment setting, unless the support is to develop customized employment, self-employment, or home-based employment (*subject to prior approval of the Division*).

Scope and Limitations

Service is available for any participant ages 18 and older. All other services approved must be based on participant need and fit within the person's assigned budget. Documentation for any supported employment service must be maintained in the provider and case manager's file for each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation or Workforce Services) or the Individuals with Disabilities Education Act [20 U.S.C. 1401 et seq.] (school district). Services cannot be provided during the school hours set by the local school district. The service requires a Third Party Liability Form. Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for training that is not directly related to a participant's supported employment program.

Relative providers (excluding parents/stepparents) may provide these services.
Transportation is included in the reimbursement rates for this service.

Provider Qualifications Note

A Supported Employment provider shall, within one (1) year of becoming certified in employment services, have one (1) employee working at least half of their time as a job coach or job developer that is certified in a nationally recognized supported employment curriculum approved by the Division for every ten (10) participants served in this service.

Supported Employment Follow Along	Comprehensive Waiver Supports Waiver ABI Waiver	T2019TS *New modifier "TS" starting 7-27-15*	$6.78	15 minute unit

Services and supports that enable a participant who is paid at or above the federal minimum wage to maintain employment in an integrated community employment setting. Service is provided for or on behalf of a participant through intermittent and occasional job support, communicating with the participant's supervisor or manager, whether in the presence of the participant or not. SEFA may cover support through phone calls between support staff and the participant's managerial staff. SEFA reimburses at a 15 minute rate for up to 100 units annually, with approved units based upon individual need in order to maintain employment. SEFA does not reimburse for transportation, work crews, public relations, community education, in-service meetings, or individual staff development.

SEFA Reimbursable Activities:

- Time spent at the participant's work site: observation and supervision of the participant, teaching job tasks and monitoring at the work site a minimum of twice a month, to ascertain the success of the job placement
- A participant may receive SEFA for working in an integrated community work environment where at least 51% of other employees who work around the participant do not have disabilities**.**
- The provision of skilled job trainers who accompany the participant for short-term job skill training at the work site to help maintain employment.
- Regular contact and follow-up with the employer and participant to reinforce and stabilize job placement.
- Facilitation of natural supports at the work site.
- Individual program development, writing tasks analyses, monthly reviews, termination reviews and behavioral intervention programs.
- Advocating for the participant, but only with persons at the employment site (i.e., employers, co-workers, customers) and only for purposes directly related to employment.
- Staff time used in traveling to and from a work site.

SEFA Non-reimbursable Activities:

- Transportation of an individual participant.
- Activities taking place in a group, i.e. work crews or enclaves.
- Public relations, community education.
- In-service meetings, department meetings, individual staff development.
- Incentive payments made to subsidize the employer's participation in a supported employment program.
- Payments that are passed through to users of supported employment programs.
- Sheltered work observation.
- Payments for vocational training or activities that is not directly related to a participant's employment objective.
- Any other activities that are non-participant specific, such as a job coach working the job instead of the participant.
- Services furnished to a minor by a parent(s), step-parent(s) or legal guardian.
- Services furnished to a participant by the participant's spouse.

Provider Qualifications Note

A Supported Employment provider shall, within one (1) year of becoming certified in employment services, have one (1) employee working at least half of their time as a job coach or job developer that is certified in a nationally recognized supported employment curriculum approved by the Division for every ten (10) participants served in this service.

Transportation	Comprehensive Waiver Supports Waiver ABI Waiver	T2003	$0.56 Annual cap of $2000	Per mile

Transportation service on the waiver is a gap service to enable participants to gain access to an employment location, community services, activities, and resources as specified by the plan of care when a service provider is not needed at the event. Service is not intended to replace formal or informal transportation options, like the use of natural supports, city transportation services, and travel vouchers. Transportation services under the waiver shall be offered in accordance with an individual's plan of care and whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge or with other resources will be utilized.

Scope and limitations

- This service does not include transportation to medical appointments required under 42 CFR 431.53 and transportation services available under the Medicaid state plan.
- Service will be reimbursed based on mileage used. Service is capped at $2,000 per year.
- Transportation must be provided by certified waiver providers who are certified for this service.
- Transportation services cannot be utilized in conjunction with or to access other waiver services that specify in the service scope that transportation is covered in the rate for that service.

Level of Service Need Scoring Rubric

Level 1: The person requires few supports weekly due to a high level of independence and functioning compared to one's peers. This person is independent with Activities of Daily Living (ADLs) but may follow checklists as reminders. No significant behavioral or medical issues that cannot be controlled with medication and routine medical care. Person requires minimal support services that can be provided within a few hours per week, and can be left alone in the home or community for extended periods of time.

Level 2: The person requires infrequent care and limited supports daily due to a moderately high level of independence and functioning. Some days may not require any support. Behavioral needs, if any, can be met with medication or informal or infrequent verbal redirection by caregivers, which may or may not require a PBSP. There may be a need for day services and intermittent residential support services to assist with certain tasks, and the person can be unsupervised for several hours at time during the day and night.

Level 3: The person requires limited personal care and/or regular supervision due to a moderate level of functional limitations in activities of daily living, requiring staff presence and some physical assistance. Behavioral needs, if any, are met through medication, informal direction by caregivers, and/or occasional therapy (every one to two weeks). Person does not require 24-hour supervision – generally able to sleep unsupervised – but needs structure and routine throughout the day. Intermittent personal attention should be given daily for training, personal care, community or social activities.

Level 4: This person requires regular personal care and/or close supervision due to significant functional limitations, medical and/or behavioral conditions. Therapy and medical care may be needed monthly in addition to support from staff. Behavioral and medical supports are not generally staff-intensive and may be provided in a shared staffing setting. Regular attention is needed throughout the day for training, personal care, reinforcement, community or social activities.

Level 5: The person requires extensive personal care and/or constant supervision due to behavioral or medical concerns or due to significant functional limitations concerns, including frequent and regular on-site staff interaction and support. Therapy and medical care may be needed bi-monthly in addition to support from staff. Behavioral and medical concerns must be addressed with written behavioral and/or medical plans and protocols. Support needs are highly intense, but can still generally be provided in a shared staff setting. Staff must provide line of sight supervision and frequent personal attention must be given throughout the day for training, reinforcement, positive behavior support, personal care, community or social activities.

Level 6: The person needs total personal care and/or intense supervision throughout the day and night. Supervision by a sole staff on-site (not shared) must be conducted by at least line of sight, with much of the staff's time within close proximity providing direct support during all waking hours. At times, the person may require the full attention of two staff for certain activities of daily living and in response to certain behavioral events. Therapy and medical care may be needed weekly in addition to support from staff. Typically, this level of service is only needed by someone with intense behaviors, not just medical needs alone. There is no ratio flexibility from the amount approved by BHD in the plan of care. Behavioral and medical supports require written plans or protocols to address support needs.